My 2017 Speech Therapy and Occupational Therapy Benefits

The Pediatric Development Center is a participating provider with Blue Cross Blue Shield and United Health Care. We submit claims for reimbursement, so our families do not have to. In order for this process to work smoothly, we require our families to research their own speech therapy and occupational therapy benefits. **PRIOR** to your initial session, please **call the insurance customer service** number on your card and use the following form to guide your conversation with the customer representative. Return this **completed form at your initial session.** Please **DO NOT** fill out this form without calling your insurer. Together we can avoid any unexpected surprises or delay in treatment. Thank you!

Client: ____ Date of Birth: ___________

BCBS / UHC/ Medicaid (circle) ID #: ___________________________________ Group: _________________

Dates of Coverage: ______________________________ Date Form Completed: _____________________

Number of Visits

No. of visits per year: _____ Per diagnosis? Yes No

Can an appeal be made for more? Yes No

Are the number of visits shared with OT PT ST Other?_____________ (circle all that apply)

Does your child receive OT, PT or ST at another private therapy center? Yes No

Patient Liability

Do you have a deductible? Yes No Amount? $_________

Amount of Copay $-OR-____ Percentage of client responsibility: ______%

Preauthorization

Is preauthorization required? Yes No

Is physician's referral required? Yes No

Is initial evaluation covered? Yes No
(if not you will be responsible for payment)

Do you need a referral for services? Yes No

If yes, did you seek a referral from your physician? Yes No (If required, please request a referral ASAP)

Treatment Codes: Following is a list of commonly used codes. Since we do not yet know your child, we do not know which codes will apply to your treatment sessions. Please ask the insurance representative if the following codes are covered under your plan. Circle all reimbursable codes.

92507 92526 97532 97530

I, _____________________________________, completed this form during a phone conversation with my insurer regarding the covered benefits under my health insurance plan. To the best of my knowledge, this information that I am providing to The Pediatric Development Center is complete and accurate. I understand that I am responsible for paying The Pediatric Development Center any charges not covered by my health insurance. This payment will be due directly upon notification.

Signature: ____ Date: ___________________________________